GUITÉRAS (R.)

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THE question of the treatment of urethritis is always an interesting one, because, although the disease is common, no specific has yet been found, and every new remedy has been discarded after universal trial, and physicians come down again to old routine treatment or grasp faintly at some new idea with which they perhaps do not fully agree.

The title of my paper may seem strange, but I have chosen it, thinking that the metropolitan treatment of urethritis is as far advanced as any and in order to avoid reviewing the immense amount of literature that I would have to were I to consider it from a broader standpoint.

The methods of treating this trouble in our first-class institutions and private practice seem to be quite similar, and, although different men cling to different hobbies and seem to have different results from the same methods, yet I may say that the

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treatment on the whole seems rational and conservative. In the best dispensaries the treatment is excellent and carried out with the utmost care, and may be outlined somewhat as follows: At present the craze for examining the discharge for the gonococcus seems to have abated, and most men seem to have arrived at the conclusion that in nearly every acute running case, and in by far the majority of the subacute cases and in those of gleet, the germ is present, and that it is quite exceptional to find it absent. This puts the consideration of the disease on a basis more similar to that of some years ago, and leads me to consider all such cases of evident acute and chronic urethral discharge as urethritis, and not by the names of gonorrhea, specific and non-specific urethritis, strains, etc. I will, therefore, first speak of acute anterior urethritis, meaning the ordinary, fresh, acute case before the process has travelled back beyond the compressor urethræ or cut-off muscle. In this condition the methods of treatment are different. Almost all agree on giving diluents in the acute stage, usually some of the potassium-salts in large draughts of water. A few others give anti-blennorrhagics, cubebs, copaiba, sandal-wood oil, or santal midi. These, together with restricted diet, seem to be all that are generally advised internally in this stage.

Locally, the treatment varies more. A number give simply hand-injections of astringents, principally the zinc-salts in mild solutions, to be used at home, while others give anterior irrigations of a saturated solution of boric acid, or a 1 : 4000 solution of potassium permanganate through a fountain

syringe having an elevation of two or three feet. In connection with this local treatment hot sitz-baths and frequent immersions of the organ in hot water are advised. The more conservative do not give any urethral treatment during the acute stage, nor do they recommend anti-blennorrhagics, advising only restricted diet, diluents in large quantities of water, hot sitz-baths, and frequent immersions for the first ten or fifteen days.

The acute stage having passed and the condition having become subacute, the diluents are kept up; also in many instances the anti-blennorrhagics, while the astringent hand-injections are increased a little in strength. The conservatives, whom I spoke of before as giving neither injections nor anti-blennorrhagics in the first stage, now become emboldened, and add these, singly or combined, to their former treatment. If these cases now become indolent, many resort to silver nitrate and irrigations of solutions varying in strength from 1 : 16,000 to 1 : 2000 are given, either anteriorly or else by injection into the bladder, and allowing the patient to expel them by urination afterward.

Cases appearing with a subacute discharge, whether fresh or old, are put on the same treatment as those that have passed into the subacute stage. In chronic cases hand astringent injections, mercuric chlorid anterior irrigations, or permanganate injections into the bladder, to be afterward expelled by urination, are generally used.

We now come to the second part of our treatment—that is, of posterior urethritis, acute, subacute, and chronic—as it occurs in connection with

one or another of the conditions of acute, subacute, or chronic urethritis.

Posterior urethritis is the extension of an anterior urethritis into the posterior urethra. Some authorities say that this extension always takes place, but that it is often so mild and transient as not to be noticed, while others estimate it as occurring in from 20 to 90 per cent. of the cases. This variance probably depends upon the fact that the difference between posterior urethritis and inflammation of the bladder were formerly not well understood, and because the Ultzmann test and other tests for locating posterior urethritis had not become so extensively practised.

When the posterior urethritis is acute the diluents are usually kept up. The anti-blennorrhagics are given by some and not by others, whilst the local treatment, when used, generally consists of silver nitrate employed in different ways. Some make at this time silver-nitrate instillations into the deep urethra, beginning at one grain to the ounce, depositing from five to twenty drops at a sitting, and increasing in strength, while others inject a few ounces of a 1 : 2000 solution into the bladder, allowing the patient to expel it by urination, and increasing this gradually to a greater strength. Anterior injections are usually omitted in these cases. The more conservative not only omit the anterior injections, but they do not trust to the use of instruments for treatment, relying on alkaline diluents, hot rectal enemas, etc., while the symptoms are acute, but taking up the stronger treatment when they become subacute.

When a subacute anterior and posterior urethritis

occur together the treatment again varies, some using astringent injections of silver nitrate, potassium permanganate, or mercuric chlorid, which they inject into the bladder and then have the patient expel by urination, while others make deep instillations of strong silver nitrate solutions and anterior endoscopic applications, recommending boric-acid solutions to be used as an injection at home.

The endoscope is not used as a routine in dispensary-practice, and seems, with the gonococcus, to be losing favor in dispensary-work.

The treatment of subacute urethritis or gleet dependent upon strictures seems to be alike with all, the rule being to dilate by sounds, as many as possible, and to cut those offering too much resistance to dilatation.

In hospitals the treatment varies in that more care can be taken of the patients and that directions for rest, baths, immersions, diet, etc., can be more thoroughly carried out. Patients treated by irrigating methods are more carefully attended to, and therefore show better results, as they can have the irrigations twice a day, with the opportunity of resting after receiving them.

In private practice patients are treated more as they are in dispensaries, as they belong to the ambulant class. The directions regarding diet, baths, rest, etc., are, however, much better carried out, and patients are often found who will come twice a day if a course of treatment by irrigations of potassium permanganate, mercuric chlorid, boric acid, or silver nitrate is recommended. Again, the surgeon can give more time to the treatment of the individual

himself, who is not subjected to the unskilful handling sometimes received from untrained assistants and nurses.

In my own cases I usually treat the acute stage by diluents and anterior astringent hand-injections. The diluent used by me at present consists of a tablet of potassium bicarbonate and potassium citrate containing enough citric acid to cause effervescence on being thrown into a glass of water, after which effervescence the solution would contain five grains of each of the potassium salts. These tablets are made for me by Fraser, and have the name of the "A. B. C. effervescing diluent tablet." I recommend them to be taken, one every three hours in a glass of water. My astringent hand-injection is a modification of Ultzmann's. It is constituted as follows:

℞.—Zinci sulphatis
Aluminis } āā . . . gr. v.
Acidi carbolici
Glycerini . . . . . f℥ss.
Aquæ destillatæ . . q. s. ad f℥iv.
M.

This is to be used three times a day after urinating and washing the anterior urethra with hot water. In rare cases, when there is a great deal of inflammation about the glans and prepuce, with perhaps lymphatic glandular complications, I do not give the injections, but simply the diluent, hot sitz-baths, a purge, followed by Rochelle salts every morning, and plenty of water. I also regulate the diet, cut off alcoholics, pepper, and tobacco, order a suspensory bandage to be worn constantly,

and show my patients how to make a butterfly-dressing to soak up the discharge.

After using many formulated injections, I have at last come down to three, which seem to be the most efficacious. If the modified Ultzmann just spoken of has no effect, I order a stronger one of the following constitution:

℞.—Zinci sulphatis . . . . gr. x.
Extracti hydrastis fl. . . . f ℥ss.
Aquæ rosæ . . . q. s. ad f ℥iv.
M.

The hydrastis used is the colorless variety, as the ordinary fluid extract has such staining properties. If this fails, I use a still stronger injection, one of Ricord's favorites, which has the following composition:

℞.—Zinci sulphatis . . . . gr. x.
Plumbi acetatis . . . . gr. xv.
Tinct. catechu } āā . . . f ℥j.
Tinct. opii }
Aquæ destillatæ . . q. s. ad f ℥iv.

This course of injections, in connection with diluents, will usually cure an ordinary case of urethritis when no posterior urethritis occurs.

If posterior urethritis does occur, I leave off my anterior hand-injections, but continue my diluents, with ten drops of belladonna three times a day in addition for the tenesmus. If the process is a very acute one, I keep the patient in bed, allowing him to get up only for two hot sitz-baths a day. I put him on a milk-and-vichy diet. If the belladonna and the diluent are not enough to control the tenesmus, I omit them, and give instead supposi-

tories of extract of belladonna and morphin, each one-quarter of a grain. I give the patient Rochelle salts for his bowels, and in case they do not produce the desired effect, give hot water enemas containing a little glycerin. So soon as there is a little abatement of the symptoms, I begin to give instillations of silver nitrate, one grain to the ounce every other day at the outset, and gradually increase in strength and put my patient on sandal wood oil, or santal midi capsules. If the sandal-wood oil, I begin with fifteen drops and increase five drops a day ; if santal midi capsules, I begin with one capsule and run up to three three times a day. If the santal midi does not do well, I give cubebs, copaiba, or the Lafayette mixture in the order of preference mentioned. This treatment will usually cure the posterior and hold the anterior urethritis in abeyance, which I then begin to treat again with mild astringent hand-injections.

If the trouble is rebellious to treatment and continues in a subacute form, I use once a day anterior irrigations of a 1 : 3000 potassium permanganate solution from a fountain-syringe elevated two feet, through a retro-injecting rubber tube passed into the bulbous portion of the urethra; and if there is a subacute posterior urethritis associated with it I allow it to run back into the bladder, either by increasing the elevation of the fountain-syringe to five feet and compressing the meatus, or by slipping the end of the catheter beyond the cut-off muscle. In cases in which this fails I substitute a weak solution of silver nitrate, beginning with 1 : 8000, and increasing to 1 : 1000, if necessary. It is not until these methods

have failed that I begin to do anything with the urethra. I then make a careful examination with an acorn-bulb bougie, and in case a narrowing is found, or stricture, I dilate with an Oberlander dilator or an ordinary Otis urethrotome. I find that for strictures of the first four inches a straight Otis urethrotome works admirably as a dilator. After dilating by a slow process, one or two millimeters at a sitting, I pass sounds of the Otis curve, anointed with equal parts of the ointment of red mercuric oxid and vaselin. If the anterior stricture is deeper than four inches, I prefer the Oberlander.

The urethra having a smooth bore and the gleety discharge continuing, I make an endoscopic examination and silver-nitrate application through it.

Of course, if a patient has had several attacks of urethritis, all of which have been of a slow or a relapsing type, I suspect strictures earlier in the disease, and do not put my patients through so many changes, relying on the cure of the stricture for the cure of the trouble.

In my hospital practice, and formerly in out-patient departments and dispensaries, I have used a treatment for acute and subacute anterior urethritis by daily injections of a mild solution of silver nitrate each time increased a little in strength. My method has been as follows: The patient is put on a diluent mixture and a hand astringent injection, the one used being the modified Ultzmann's, previously referred to. I then give once a day an injection of a silver-solution in the following way: The patient, after passing urine, has his anterior urethra washed out with warm water, and a syringeful of silver-solution

is then injected and allowed to escape immediately. A syringeful of a saturated solution of boric acid is then injected and retained for five minutes, and the patient is then requested not to pass his urine until as long a time as possible has elapsed.

The greatest care should be taken in the preparing and keeping of this solution, and it should never be increased beyond ten grains to the ounce, or 2 per cent. in strength. The best method of keeping it is to have ten colored bottles filled with the different strengths of the solution, from one to ten grains to the ounce. These injections should be made with the greatest care, increasing one grain in strength each day. No pain is noticed by the patient excepting a little burning on the third and fourth injections. The patient's discharge is usually checked or reduced to a little watery secretion on the seventh or eighth day, when the silver-treatment is left off and the patient is put on anti-blennorrhagics and hand injections for a week, and directed not to drink or indulge in venery or other excesses for a period of three weeks. It is never necessary to go beyond a ten-grain solution. If the discharge has not ceased at this period, the treatment should be changed for astringent injections and anti-blennorrhagics. By this method eighty per cent. of the cases treated have been apparently cured in less than ten days. If posterior urethritis occurs or complications develop, such treatment should be immediately changed.

From my observations I derive the following conclusions: (1) That it is impossible to treat urethritis according to any given rule at the present day, a successful method not as yet having been discovered.

2. That specialists are much better able to treat it successfully than the general physician, and, to go further, that a patient receives better treatment from a specialist in a dispensary than from a general physician in private.

3. That injections checking all discharge or reducing it to a moisture about the meatus, such as those of mercuric chlorid, potassium permanganate, and silver nitrate, are the most successful means of treating a fresh attack, and that of these silver nitrate is the one upon which most reliance can be placed.

4. That in all cases the patient should be treated conservatively, and the treatment should be modified according to the symptoms.

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